

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5848

63-040222

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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2 331.8

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12 51-0

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF
Stanley Hellerstein
MEDICAL CERTIFICATION

FILED NOV 7 1963

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City		c. CITY OR TOWN Kansas City	
Length of stay in 1b 10 mos.		Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) Children's Mercy Hospital		d. STREET ADDRESS (If outside, give location) 2335 Cleveland	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sharon Denise Washington		4. DATE OF DEATH 10-26-63	
5. SEX Female	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-10-62
9. AGE (last birthday) 10 Months 16 Days		IF UNDER 1 YEAR IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (City and state or country) K.C., Jackson, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Gene Washington		13b. MOTHER'S MAIDEN NAME Leticia Jones	
14. NAME OF HUSBAND OR WIFE Infant		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. -----		17. INFORMANT Gene Washington (Father)	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Disease of the R-E system Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 9/30/63 to 10/26/63 and last saw her alive on 10/26/63 Death occurred at 10:35 a on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) Stanley Hellerstein, M.D.	
22b. ADDRESS 1710 Independence Ave.		22c. DATE SIGNED 10/26/63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/30/63	
23c. NAME OF CEMETERY OR CREMATORY Blue Ridge Lawn		23d. LOCATION (City, town, or county) (State) Kansas City, Missouri	
24. FUNERAL DIRECTOR Mrs. Meek's Mortuary		25. DATE RECD. BY LOCAL REG. K. C. Mo. 10-28-63	
26. REGISTRAR'S SIGNATURE Basile Smith			

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Millard B. Perkins

Licensed Embalmer No. 5013

P. O. Address K. C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.